Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005047	A. BUILDING: _____ B. WING _____	C 01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH BLOOMINGTON HOSF	601 W SECOND ST BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Date of survey: 1-10-14 Facility number: 005047 Complaint number: IN00139906 Unsubstantiated; lack of sufficient evidence Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Indiana University Health Bloomington Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, Medicare Conditions of Participation. QA: claughlin 01/28/14	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE